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Centers for Disease Control  
and Prevention (CDC)  
Atlanta GA 30333  
TB Notes  
Vol. 2, 1996

Dear Colleague:

As you know by now, overall TB cases in the United States have again declined. There was a 6.4% decrease in the number of TB cases reported in the United States, from 24,361 new cases in 1994 to 22,812 new cases in 1995; case rates decreased from 9.4 per 100,000 population to 8.7 per 100,000 population, the lowest rate for reported TB cases since national surveillance began in 1953. As the director of the national program to prevent and control TB in the United States, I am gratified by this now third consecutive yearly decline in TB cases. On March 22, I participated in a World TB Day press conference in Washington, DC, where I announced the reduction and provided an update on numbers of cases and TB trends in the United States. I talked about some of our successes in the fight against TB as well as the continuing challenges we face. For example, while the overall number of U.S. cases has decreased, 18 states reported no change or more cases in 1995 compared to 1994. And although there has been a decreased number of TB cases among U.S.-born persons, the percentage of cases among foreign-born persons continues to increase, from 32% in 1994 to 36% in 1995. While we can be proud of our accomplishments, we must sustain our efforts to ensure that all persons with TB are promptly diagnosed and treated.

The Advisory Council for the Elimination of Tuberculosis (ACET) met on April 25 and 26 in Atlanta. After Dr. Starke, Dr. Gayle, and I gave our updates and reports, we heard a preliminary analysis of the 1995 TB morbidity data; there was also continued discussion of a draft ACET letter and recommendations to HHS Secretary Donna Shalala on the prevention of TB in foreign-born persons. The council then heard presentations on gene amplification tests for the rapid diagnosis of TB; data were presented from the trials of the Gen-Probe® and Roche rapid diagnostic tests. The other major topic of discussion at the meeting was managed care, and its possible impact on public health practice in the United States.

The annual American Thoracic Society (ATS)/American Lung Association (ALA) International Conference was held May 10-15 in New Orleans this year. As usual, there were many excellent presentations on TB. Particularly noteworthy were the session on DNA fingerprinting and the appropriate use for rapid diagnostic tests for TB, as well as the TB public health poster session that was held on Monday evening, May 13. It was announced at the meeting of the Scientific Assembly on Microbiology, Tuberculosis, and Pulmonary Infections that Jeffrey Starke, MD, current chairman of the assembly, has completed his term in that post and will be replaced by Richard Chaisson, MD, Division of Infectious Diseases, Johns Hopkins University School of Medicine and Medical Director, Baltimore City Health Department TB Control Program.

Videotapes of the course *A Satellite Primer on Tuberculosis* have been edited and provided to the Satellite Course Coordinators for each state; the coordinators are responsible for distribution of these tapes. The videotapes should be used to supplement the *Self-Study Modules on Tuberculosis*. The modules and videotapes are designed for entry-level public health TB workers with little or no experience with TB. Please see the ordering information for these videotapes in this issue of *TB Notes*.

The reorganization of our center has finally been approved; we are formally designated the National Center for HIV, STD, and TB Prevention (NCHSTP). Please see this issue of *TB Notes* for the official names of the activities, branches, and sections of DTBE.

A new Program Coordination Unit (PCU) has been established as a pilot program in the Prevention Support Office of NCHSTP. The PCU was formed as a consequence of the CDC reorganization that consolidated HIV/AIDS, sexually transmitted disease, and TB prevention programs into our new center, and will test the feasibility of using multiprogram consultants to serve as the contacts for state officials in all three program areas. The pilot program will serve the following TB cooperative agreement areas: Houston, San Francisco, Los Angeles, Texas, Florida, South Carolina, District of Columbia, Rhode Island, and Vermont. The PCU is now fully staffed; it includes Cynthia Marshall, Dennis Christianson, and Nick Farrell as Program Coordination Officers (PCOs) and Louis Salinas as the chief. The three PCOs are currently undergoing a thorough training and orientation with each of the three NCHSTP divisions. In addition, during this transition period they will be meeting with and accompanying TB Program Consultants on site visits to each of the nine PCU areas. Although new to this unit, each of the PCOs brings a wealth of experience to their new assignment. During May and June, the PCOs worked with each of the divisions to learn the specific program information to enable them to carry out their new responsibilities. A formal evaluation of the pilot program has been designed and will begin with an initial questionnaire, completed during June by the HIV, STD, and TB program managers in the nine PCU pilot areas and in nine control areas. The pilot period began July 1 and is scheduled to run through June 1997. For additional information, you may contact Mr. Salinas or any of the PCOs at (404) 639-8025.

For those of you who need technical assistance with the TB Database System (TBDS), please note that the individual to contact in DTBE is Mr. Bryan Cooke. He replaces Mr. Rich Niersbach as the TBDS contact point for field staff. Bryan, who can be reached at (404) 639-8155, will be glad to answer your questions.

Kenneth G. Castro, MD

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NOTE: The use of trade names in this issue is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

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—Reported by Doris Fields, MA,  
and Judy Gorjanc, RN  
New Mexico TB Control Program

### NYC TB Drug Costs and Regimens

With increases in TB drug costs, recurring budget constraints, and increased use of its clinics, the New York City (NYC) Bureau of TB Control has found it essential to keep medication costs to a minimum while continuing to provide optimal patient care. Below are approximate costs of NYC's anti-TB drugs and regimens in standard doses and Public Health Service prices. NYC physicians are encouraged to select the best regimen for their patients, but to

Drug	Dosage	\$/Mo.
INH	300 QD	\$1.23
B6	50 QD	\$0.55
RIF	600 QD	\$18.84
PZA	1500 QD	\$59.77
EMB	1200 QD	\$70.35
Rifater	6 QD	\$135.00
Rifamate	2 QD	\$22.57
Streptomyc.	1000 QD	no chge.
Kanamycin	1000 QD	\$29.40
CAP	1000 QD	\$428.70
Ofloxacin	800 QD	\$87.00
CIP	1500 QD	\$153.00
CYC	750 QD	\$179.10
Ethionamide	750 QD	\$76.05
PAS	12G QD	\$239.45
Clofazimine	100 QD	\$4.40

Regimen	\$/Mo.	Total \$
12 m H	\$1.23	\$15
4 m (HRZ)E	\$205	\$821
4 m (HR)	\$23	\$90
2 m (HR)ZE/ 2 m (HR)	\$130/ \$23	\$305

Regimen	\$/Mo.	Total \$
2 m HRZE; 4 m HR [DOT]	\$150/ \$20	\$381
2 m HRZE; 4 m H <sub>2</sub> R <sub>2</sub> [DOT]	\$150/ ~\$6	\$324
6 m H <sub>3</sub> R <sub>3</sub> Z <sub>3</sub> E <sub>3</sub> [DOT]	\$111	\$488
2 m (HRZ)E; 4 m (HR)	\$205/ \$23	\$501
½ m HRZE; 1½ m H <sub>2</sub> R <sub>2</sub> Z <sub>2</sub> E <sub>2</sub> ; 4 m H <sub>2</sub> R <sub>2</sub> [DOT] "Denver"	\$38(½m) \$101 \$6	\$210
8 m CAP+CYC +CIP+PAS; 24 m CYC+ CIP+PAS [MDR]	\$1,000/ \$572	\$21,719

m=month; H=INH (isoniazid); R=RIF (rifampin); Z=PZA (pyrazinamide); E=EMB (ethambutol); CAP=capreomycin; CYC=cycloserine; CIP=ciprofloxacin; PAS=para-aminosalicylic acid; ( ) = combination formulation; subscript nos.= no. of observations per week.

There have been minor changes in some of these prices since this article was written, but the relative costs remain essentially unchanged.

select the most economical one when treatments are equivalent.

As a result of analyzing these costs, the Bureau instituted these policy changes:•

- Patients in the NYC program being started on a fluoroquinolone will be given ofloxacin instead of ciprofloxacin. (Exceptions to this are patients with renal insufficiency, since ofloxacin accumulates and is not dialyzed effectively, and patients with ofloxacin intolerance; ciprofloxacin will be used for these patients.) Other than price differences, there is more published evidence for the efficacy of ofloxacin than for ciprofloxacin. The usual dosage of ofloxacin is 600-800 mg/day, based on weight. Patients with absorption problems may require 1200 mg/day; drug levels should be checked when appropriate.
- The Bureau has decided to reduce Rifater use, since the initial phase is being supervised and combination tablets cost more than the individual component drugs. Rifamate, however, will continue to be used for patients not on directly observed therapy. Individual pyrazinamide and ethambutol will continue to be used when clinically indicated.
- The Bureau has revised its “4/4/4” protocol (Class IV patients/4 drugs/4 months). Patients who are truly Class IV—tuberculosis, not clinically active: no symptoms, no cavity, no “soft” infiltrate, no documentation that their x-ray has changed in the past year—will be started on self-administered Rifamate (INH and rifampin), ethambutol, and PZA. After the first 2 months of treatment, if the sputum cultures have not returned as positive (even if still pending), ethambutol and PZA will be stopped and Rifamate continued for 2 more

months—still 4-month therapy. This regimen is based on trials which used INH and rifampin alone for 4 months and showed high levels of treatment efficacy for culture-negative TB. If smears or cultures return as positive, standard treatment will be given. Twelve months of INH will still be an acceptable option for Class IV patients; however, the multidrug regimen is preferred.

- All medications will be given only as long as indicated per protocol. In particular, intensive-phase treatment will only be continued as long as necessary. Ethambutol will be discontinued as soon as susceptibility is documented. Pyrazinamide, which is recommended for 8 weeks or until smear negative or whichever is longer, can be discontinued after 8 weeks of treatment, pending sputum results; patients can be called back if their results are smear-positive. Since smear-positive patients should be on DOT, calling back those with positive smears should be easy.
- When an injectable drug is indicated, streptomycin is generally the preferable agent if in vitro susceptibility to streptomycin has been shown. The minimum inhibitory concentration and the cost are lower for streptomycin than for other injectable drugs.

The NYC Bureau of TB Control believes that the above changes will not compromise patient care; at the same time, the financial savings of these changes will be substantial. All other clinical protocols will remain unchanged. The Department of Health and the City of New York remain 100% committed to ensuring complete, appropriate, and optimal care of patients in its clinics.

*—Reported by Tom Frieden, MD, MPH  
Director, NYC Bureau of TB Control*

### **The Maine On-Line Pharmacy System**

On November 27, 1995, the Maine TB control program went “on line” with a statewide computerized pharmacy link that allows patients to fill their prescriptions for TB medications at local area pharmacies. This on-line system was developed over an 18-month period by the TB control program, the Bureau of Medical Services, and a privately contracted data processing company. This new state-of-the-art drug delivery system relieves the state of the responsibility for shipping medications statewide.

When a physician notifies the TB control program that a patient is to be placed on TB medication, the TB control program enters an approval ID number and the length of treatment into the computerized pharmacy link. This notification automatically makes the patient eligible to receive medication, free of charge, for the specified and agreed-upon length of treatment. When an approved patient presents a prescription for, or picks up, TB drugs at the chosen pharmacy, the pharmacist submits the claim to the TB control program via the computer link, and the claim is automatically approved for the entire length of that prescription. However, if the TB control program did not receive prior notification from the prescribing physician, the patient will not be on file and will not have an ID number. In these cases, the pharmacy can only dispense a starter supply of TB drugs (up to 2 weeks’ duration), and notify the TB control program through the computer of these patients for follow-up and future ID assignment. The TB control program

requests that all providers offer prior notification when the decision is reached to place a patient on TB medication. In most situations the patient can gain eligibility in the system immediately. This will save time, paperwork, and starter supplies.

The TB control program is able to arrange for patients to receive their medications from a pharmacy through a variety of mechanisms. In most situations, the patients are allowed to obtain their own medications at selected area pharmacies. As a safeguard, the computer link will automatically notify the TB control program if medication is not picked up within 48 hours. Other mechanisms such as delivery by a public health nurse and direct pharmacy delivery are used for select groups of patients, including persons with active and suspected disease.

Rebate structures and pricing discounts have kept costs of the new delivery system comparable to those of the previous system. The major advantages of privatizing TB medication delivery are

- Improved medication delivery time to TB patients (from 5-7 days to <24 hrs)
- Elimination of the state’s responsibilities for labeling and mailing TB medications
- Greatly improved program surveillance
- Substantially reduced program staff time

The transition of the TB medication delivery system from a state-controlled system to a private one has been a tremendous success for the TB control program in Maine and may prove to be a useful prototype for other rural states and areas around the country.

—Reported by Bernard Benecke  
Maine TB Control Program

### **South Dakota Improves Delivery of Preventive Therapy with 7-Day Pill Pack**

Starting in 1994, the TB control program in South Dakota has seen yearly increases in the number of TB cases among foreign-born persons. In 1994, 18% of the reported TB morbidity was in the foreign-born population; in 1995, 25% was in foreign-born persons (the state's highest percentage of TB cases ever reported from this group). In addition, South Dakota also saw high rates of TB skin-test positivity in new refugees entering the state, with more than 50% of these refugees testing positive. This high rate of infection, combined with the resettling of several hundred refugees each year in the state, resulted in many patients who need preventive therapy each year.

Previous attempts to provide preventive therapy to foreign-born patients by providing a 1-month supply of INH have not been successful. In calendar year 1994, a total of 164 foreign-born persons were TB skin-test positive; of these, 143 (87%) were started on INH with monthly refills. The outcome of this effort resulted in 27 (19%) patients completing an adequate course of preventive therapy within 6 months. A total of 116 (81%) did not complete their preventive therapy for a variety of reasons: 103 patients (72%) were noncompliant, 10 (7%) moved, and 3 (2%) could not be located.

Owing to this unsuccessful attempt to intervene with preventive therapy, the South Dakota Department of Health was prompted to create a new mechanism to deliver preventive therapy to foreign-born persons. However, any new approach

would still need to be conducted within the current budget and staffing limitations.

The approach that was devised is a "hybrid" program that allows closer monitoring of patients on preventive therapy without the time and staff that are required to deliver biweekly DOPT to patients. Through this new program, patients are offered preventive therapy through what is called the "7-Day Pill Pack Program." Patients are provided a 1-week supply of medication in a 7-day pill pack. The TB outreach worker makes a weekly visit to deliver and refill the pill pack and thus sees the patient four times a month, versus once a month with the previous system. The biggest advantage to this system: since the outreach workers visit each patient once a week, they can see twice as many patients as those workers using a biweekly DOPT program.

This program was implemented in July 1995 in southeastern South Dakota, where virtually all foreign-born persons in the state resettle. Since then, 123 foreign-born persons have been started on the 7-Day Pill Pack Program. The results, as of March 22, 1996, are very encouraging: 34 patients (28%) had completed a 6-month course of preventive therapy and 70 patients (57%) were still on a recommended course of therapy. Nineteen patients (15%) did not complete their therapy; of these, six (4%) were noncompliant, seven (6%) moved, two (2%) could not be located, three (2%) had medication side effects, and one (1%) became pregnant.

Anecdotal evidence also supports the success of this program. For example, there is an increased interest in TB by the families of patients. TB outreach workers have reported that while delivering a 7-day pill pack to a patient, they will be asked questions about TB by other persons in the

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household. As another example, when a TB outreach worker could not deliver medication one day because of blizzard conditions, two patients on the 7-Day Pill Pack Program walked in blowing snow to the Department of Health offices to make sure they got their pill packs refilled. Although this program is currently less than 1 year old, we have evidence that it can keep patients on preventive therapy and help them follow through to completion. Further experience will show whether these initially encouraging results continue to be seen. Because this hybrid program merges the best aspects of DOPT programs and monthly refill programs, it appears to be a workable strategy to allow for completion of preventive therapy in high risk groups, while allowing outreach workers to see more patients.

—Reported by Kristin Schweigert  
South Dakota TB Control Program

### **Projects for Homeless Clients in New Orleans**

In 1994, homeless persons accounted for 4.5% of the 433 total TB cases in Louisiana; in 1995, this group had approximately 5.5% of the 476 TB cases statewide. In the New Orleans region, homeless persons accounted for 9.6% of the 147 TB cases in 1995. The most recent estimate of the number of homeless persons in Louisiana is about 72,000; approximately 15,000 of these are in New Orleans. Until recently, homeless persons in New Orleans were skin tested for TB at a primary-care clinic that serves only the homeless. Those individuals with positive skin test results or signs and symptoms of TB were referred to the Wetmore TB Clinic for chest radiographs and evaluation by a physician. However, only 50% of the homeless actually went to the Wetmore Clinic because of a lack of transportation

and delays between reading the skin tests and taking the chest radiographs.

In October 1995, Robert Little, MD, proposed providing a TB clinic onsite at the New Orleans Mission, one of the major homeless shelters in New Orleans, to include the essential components of care—specifically, skin tests, chest radiographs, and physician services—at the same location. He proposed that on the day the skin tests are read, clients would have chest radiographs and be evaluated by Dr. Little. If preventive therapy is indicated, clients would start medication the same day. Furthermore, the plan included the services of a nurse to work in the clinic and conduct outreach services to provide directly observed preventive therapy to homeless persons. In order to promote compliance, Dr. Little and TB program staff visited four major shelters in New Orleans and asked the directors to consider guaranteeing bed space for those homeless persons who are taking their preventive therapy medications. The shelter administrators were receptive to this idea. As of June 1 the status of this project is as follows:

- Through the State of Louisiana's Office of Public Health, a contract was initiated for Dr. Little to provide TB services in the New Orleans Mission homeless shelter for 6 hours per week. The contract was approved and was effective January 1, 1996.
- A proposal was submitted to the Charles and Elizabeth Wetmore Foundation for the purchase of an x-ray machine for the New Orleans Mission. The Foundation has agreed to pay for the machine; delivery is expected this summer.

- The New Orleans Mission shelter is renovating the onsite clinic and preparing the site for the x-ray equipment. The shelter will cover these costs through donations and fundraising activities. The renovations are expected to be completed soon.
- In the interim, until the renovations at New Orleans Mission are complete, Dr. Little has been providing TB services to the homeless in the primary care clinic that serves homeless persons. Since the provision of chest radiograph services still presented an obstacle, TB staff met with a company that provides those services and negotiated a contract to provide them for homeless clients. The chest radiograph services, which are paid for by the Wetmore Foundation, are provided across the street from the primary care clinic.
- At least two major shelters have agreed to dedicate bed space for those clients who comply with preventive therapy.
- One nurse will volunteer a portion of her time to work in the TB clinic and to provide directly observed preventive therapy (DOPT) outreach services. It had been anticipated that the Baptist Foreign Mission Board would provide a grant or stipend for one nurse for these services, but this did not materialize because individuals who own houses or other property are not permitted to receive a grant from this entity.

Another project for homeless persons underway in New Orleans is the placement of ultraviolet (UV) lights in four major shelters. Dr. Little and TB program staff visited the shelters in November and

December 1995 to discuss placing UV lights to reduce the risk of transmission of TB among homeless clients and shelter staff. All four are interested in participating in this project and have given the Louisiana TB control office their estimates of the number of lights needed and the costs of installation. The projected cost of this effort is \$38,000; the Wetmore foundation has agreed to fund this project.

—Reported by Vic Tomlinson  
Louisiana TB Control Program

### Clarification of New DTBE Distribution Policy

In the last issue of *TB Notes* (Volume 1, 1996), we announced that DTBE would be changing its policy for distributing training and educational materials. At this time, the change applies **only** to the distribution of **slide sets** with any accompanying narratives and videotapes. DTBE will continue to provide at least one copy of each new slide set and videotape to state and territorial TB control officers, big city TB control officers, DTBE public health advisors, TB nursing contact persons, and members of the Advisory Council for the Elimination of TB. Additional copies of the slide sets and videotapes will be available for purchase only. Currently available slide sets include:

- *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities, 1994* (Order number AVA19824SS00)
- *Core Curriculum on Tuberculosis, 3rd edition, 1994* (Order number AVA19830SS00)

Sales of the slide sets will be provided through the National Technical Information Service (NTIS) in Springfield,

Virginia. To order, call NTIS at (703) 487-4650 and request the product number desired. Each set costs \$50.00 plus shipping and handling.

Other training and educational materials will be available, as in the past, at no cost to our constituents. We do ask, however, that any distribution of DTBE materials by state or local TB programs be targeted to persons or organizations in greatest need. The number of copies per order may be limited for certain items.

—Reported by Susan M. Graham, MPH  
Division of TB Elimination

### **San Francisco Model TB Program Holds Program Manager's Course**

From January 30 through February 2, 1996, the Francis J. Curry National TB Training Center in San Francisco conducted a 4-day TB program manager's course. This pilot course was attended by 16 people, 12 from California counties and four others representing Alaska, Arizona, Nevada, and Washington. The need for this course was first identified through a training needs assessment that was conducted when the TB Training Center was first established in 1994. Survey respondents expressed the need for a course that focused on programmatic issues faced by local (city or county) TB program managers (in contrast to the CDC's former *TB Today!* course which targets state and big city TB controllers).

A precourse assessment was conducted with individuals who had expressed interest in attending the course. Two methods were used to shape the curriculum and to elicit the specific needs of the course applicants: (1) a focus group

discussion was conducted with Bay Area program managers; and (2) course applicants responded to written questions regarding their interest in the course. Additional input into the curriculum was provided through individual discussions with TB control staff, both at county health departments and at CDC. Course objectives were developed that focused primarily on developing the knowledge and skill areas necessary to administer an effective TB control program.

Course faculty were recruited from many different areas of the country. Wanda Walton (DTBE) served as the course facilitator. Additional faculty included Alan Bloch, Medical Epidemiologist, also with DTBE; Barbara Cole, Communicable Disease Director for Riverside County, California; Tony Paz, Program Manager of San Francisco's TB control program; Carol Pozsik, TB Controller for South Carolina; and Gisela Schecter, TB Controller for San Francisco. Additional faculty were from the University of California, San Francisco; the San Francisco Department of Public Health; and the Health Education Department at San Francisco State University.

On the first day presenters were charged with providing participants with a thorough foundation in the essential nonclinical components of a TB prevention and control program. Topics included principles of TB control; epidemiology of TB; surveillance; outcome measures; and a session titled "A Team Approach to TB Control," which addressed the role of program managers, their interface with team members, TB case management, nonclinical patient management issues, field follow-up, and TB control in a managed-care environment.

On subsequent days, additional topics included program management reports, a “hands-on” interactive computer session using Epi-Info programs, legal issues in TB control, and budget development and management. In addition, all participants spent 3 hours on a walk-through of the San Francisco TB control program operation.

The wealth of TB control expertise the participants brought with them was evident during the group discussions throughout the course. Additionally, some participants provided short presentations about innovative and/or successful strategies used in their programs. The presentations addressed issues as diverse as hospital discharge planning, TB control strategies in a rural setting, collaboration with community-based organizations, and the use of DOT to promote treatment adherence. The participants’ feedback to the course developers confirmed that they appreciated the opportunity to learn about their colleagues’ programs.

The need for two specific skill-building sessions had been revealed in the course planning process. An updated program policy and protocol manual is necessary for a TB control program to run efficiently, and it was found that most program managers were unlikely to have the time to develop one. Subsequently, one section of the course provided an overview of existing program manuals from various jurisdictions across the country and gave participants an opportunity to develop an outline of a manual for their own programs.

The second skill development area identified in the planning process was program planning and grant writing, both, typically, responsibilities of program managers. To respond to this need, the entire fourth day of the course was devoted

to this subject. The class was divided into small groups, representing hypothetical jurisdictions similar to the participants’ areas. After the instructor provided an overview of each step in the program planning process, the members of each small group developed, in writing, their hypothetical jurisdiction’s program plan, including a problem statement; a needs assessment plan; a set of objectives; and a plan for program design, implementation, and evaluation. After each working session, all teams reported back to the larger group, until all aspects of the program plan were completed. Course participants found this exercise to be extremely useful and beneficial.

Overall, both the participants and the course developers felt that this pilot course was a success. Participants completed a comprehensive evaluation of all faculty, their presentations, and each session of the course syllabus. They also provided useful feedback regarding what kind of curriculum modifications could be made to better suit their needs. Suggestions included more discussion about managed care implications for TB control programs and increased “hands-on” computer time. The course developers and faculty will make modifications to the curriculum, based on suggestions from both participants and faculty, prior to the next offering of the course. In addition, adjustments to the curriculum will be made based on the specific needs of future course applicants.

The National TB Training Center in San Francisco will not conduct the Program Manager’s Course again in 1996. The 1997 Training Center schedule has not yet been developed, but the course will likely be offered sometime during the first half of that year. The National TB Center in New Jersey offers a similar course for program

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managers; their next course will be conducted in November 1996.

—Reported by Cathy Miller, MPH  
Training Coordinator  
Francis J. Curry National TB Center

## **The National Coalition to Eliminate Tuberculosis (NCET)**

The National Coalition to Eliminate Tuberculosis (NCET) is an umbrella group cosponsored by CDC and the American Lung Association that has the goal of educating professionals and the public about TB. It consists of over 80 groups representing government agencies, nonprofit organizations, community-based organizations, professional societies, universities, private companies, and international nonprofit organizations. The membership is divided into four task forces: (1) Professional education, (2) Policymakers, (3) Community-based organizations, and (4) Information, communication, and education. Each task force is charged with informing, educating, advocating for, and gathering information from (as well as disseminating information to) the population segment that it represents. Each task force meets several times annually by conference call (the frequency depends on the project currently being undertaken). The total membership meets annually. This year they met January 18 and 19 in Washington, DC, at the Washington Vista Hotel.

As cosponsors of NCET, the American Lung Association and CDC have borne the majority of the costs of the organization since it was established. Last year, however, the American Lung Association sought, and was awarded, a \$120,000 grant from the Robert Wood Johnson Foundation. The grant, which was

awarded on a 2-year basis, will cover the costs of a Project Coordinator, a part-time clerk, the annual meeting, and other projects, such as *NCET News*, a quarterly newsletter distributed to members and other interested parties.

At present, there are no membership criteria. To become a member of NCET, simply call the Project Coordinator, Ms. Jocelyn Jackson, at (212) 315-8718 and ask to be placed on the membership list. One of the issues that we are working on is setting up a dues structure for NCET members. A stipulation of the Robert Wood Johnson grant was that NCET take steps to become self-supporting. The issue was briefly discussed at the annual meeting in January. At present, a series of proposals is being put together to submit to the membership-at-large for discussion. Suggestions and comments from members and interested supporters are always welcome.

—Reported by Jocelyn Jackson, MPA  
NCET/American Lung Association

## **NEWS BRIEFS**

The reorganization and redesignation of our center from the National Center for Prevention Services to the National Center for HIV, STD, and TB Prevention has been formally approved. As a result of the reorganization, DTBE now consists of the following components:

- Office of the Director
  - International Activity
- Communication and Education Branch
- Computer and Statistics Branch
- Field Services Branch
  - Field Operations Section I
  - Field Operations Section II
- Research and Evaluation Branch
  - Prevention Effectiveness Section

Therapeutics and Diagnostics Section  
Surveillance and Epidemiology Branch  
Epidemiology Section  
Surveillance Section

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The Global TB Programme of the World Health Organization (WHO) in Geneva, Switzerland, is seeking applicants for several positions. The following openings are available:

- **Public Relations Specialist:** This individual will be responsible for promoting World TB Day; publicizing major reports; and conducting other media relation activities. The applicant must have a proven track record of successfully developing and managing extensive, multifaceted publicity campaigns. Salary: \$50,000 to \$90,000, tax-exempt.
- **Writer/Editor:** Responsible for researching and writing reports and newsletters on the global TB epidemic. Must be exceptionally talented in writing for general popular publications as well as popular health publications, and possess extensive experience in managing all facets of the publications process. Salary: \$50,000 to \$90,000, tax-exempt.
- **Health Promotions Fellow:** This position presents an opportunity for an exceptionally bright and ambitious health communications graduate student to gain hands-on experience promoting TB control policies in developing countries. Must have 5 years' experience living in a developing country and possess exceptional verbal and written persuasion skills. Ten-month

fellowship with a \$20,000 stipend, tax-exempt

- **Public Relations Aide:** Short-term contracts are available for qualified graduate students and entry-level individuals to assist in publicizing the TB epidemic. Must have previous public relations work or internship experience, and possess excellent verbal and written communications skills. Three month contracts with a \$3,000 stipend, tax-exempt.

New hires will be based in Geneva and may have substantial opportunity for international travel. Interested candidates should send a resume, cover letter, and three writing samples (not returned) to: Kraig Klaudt, Global TB Program, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland. Fax: 011-41-22-791-4199

## PREVENTION EFFECTIVENESS

### National Survey of TB Outreach Workers and Outreach Activities

The purpose of this survey was to describe the outreach activities and outreach workers of TB control programs to assist in developing future evaluation and training projects. We developed a questionnaire consisting of two sections: one asked about outreach activities and the second section asked about outreach workers. For this survey, we defined an outreach worker as an employee hired primarily to deliver services outside the public health facility. The survey instrument was mailed to all 68 CDC cooperative agreement recipients. Fifty-eight programs—43 states, 9 cities, and 6 territories—responded to the survey. Of the 58 programs that responded, 53

provided information on individual outreach workers. These 53 programs included 38 states (reporting on 575 outreach workers), 9 cities (reporting on 494 outreach workers) and 6 territories (reporting on 27 outreach workers).

Fifty-seven programs reported providing outreach services: 54 in both the public health clinic and field, 1 only at the public health clinic, and 2 only in the field. The responding programs provide a variety of outreach services. Most notably, almost all of the programs provide directly observed therapy outside of the public health clinic and a majority provide DOT at the public health clinic. Outreach services are provided by many different program employees, whether or not they are classified as outreach workers; for example, Public Health Nurses (PHNs) and Registered Nurses (RNs) provide outreach services in 88% (n=50) of the TB control programs.

There are a total of 1,096 outreach workers employed by the 53 programs that provided this information. These programs reported 17,336 cases of TB in 1994; therefore, the average ratio of outreach workers to incident cases of TB is 6 outreach workers per 100 cases of TB, or 1 outreach worker for every 15-20 cases of TB. Outreach workers are racially and ethnically diverse: 40% are black, not Hispanic; 27% are white, not Hispanic; 20% are Hispanic; and 8% are Asian or Pacific Islanders. Fifty-four percent of outreach workers have non-nursing college degrees with an additional 17% having nursing degrees. Forty-three percent of outreach workers speak another language in addition to English. The language that is most frequently spoken other than English is Spanish, followed by French, Vietnamese, and Chinese.

A high proportion of outreach workers (73%) are partially or fully funded through the CDC cooperative agreements. This highlights the vulnerability of TB control in the United States to cuts or shifts in Federal funding. Loss of Federally funded outreach workers would affect all regions of the country and all incidence areas, low as well as medium and high. Without Federal funds, almost half (45%) of the programs would not have any outreach workers. Since three fourths of outreach workers who speak a foreign language are Federally funded, delivery of outreach services to non-English speaking populations would be substantially affected. If the number of TB cases in this country are significantly reduced, adequate support of TB control efforts may be removed and funds for outreach activities and outreach workers may be shifted to other programs. It is important to document the need for and effectiveness of outreach workers and their activities so that adequate resources for these programs are maintained.

"Outreach worker" is a designation applied to a heterogeneous group of TB program employees from differing educational and cultural backgrounds. Given these differences, evaluations of the effectiveness of outreach workers will require some flexibility. For example, the duties and expectations of a registered nurse would be different from those of a college graduate or a high school graduate. In addition, the needs, problems, and patient characteristics of an area would need to be considered in such evaluations. More detail is needed on what outreach workers do. To obtain this detail, the Prevention Effectiveness Studies Unit will begin an ethnographic study of outreach workers this summer. This will involve study staff observing outreach workers on the job and recording their observations,

including a description of the tasks performed and the amount of time required to accomplish the assigned tasks. The results of these descriptive studies will provide information on how to best use outreach workers as well as suggestions for optimal training and supervision.

—Reported by Zach Taylor, MD  
Division of TB Elimination

## NEW PUBLICATIONS

American Academy of Pediatrics Committee on Infectious Diseases. Update on tuberculosis skin testing of children. *Pediatrics* 1996;97(2):282-84.

Bifani PJ, Plikaytis BB, Kapur V, et al. Origin and interstate spread of a New York City multidrug-resistant *Mycobacterium tuberculosis* clone family. *JAMA* 1996;275:452-57.

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Bloch AB, Simone PM, McCray E, Castro KG. Preventing multidrug-resistant tuberculosis. *JAMA* 1996;275:487-89.

Burwen DR, Bloch AB, Griffin LD, Ciesielski CA, Stern HA, Onorato IM. National trends in the concurrence of tuberculosis and acquired immunodeficiency syndrome. *Arch Intern Med* 1995; 155(12):1281-86.

Camins BC, Bock N, Watkins DL, Blumberg HM. Acceptance of isoniazid

preventive therapy by health care workers after tuberculin skin test conversion. *JAMA* 1996;275(13):1013-15.

Cauthen GM, Dooley SW, Onorato IM, et al. Transmission of *Mycobacterium tuberculosis* from tuberculosis patients with HIV infection or AIDS. *Am J Epidemiol* 1996;144:1-9.

CDC. Essential components of a tuberculosis prevention and control program; and Screening for tuberculosis and tuberculosis infection in high-risk populations: recommendations of the Advisory Council for the Elimination of Tuberculosis. *MMWR* 1995;44(No. RR-11).

CDC. Multidrug-resistant tuberculosis outbreak on an HIV ward--Madrid, Spain, 1991-1995. *MMWR* 1996;45(16):330-33.

CDC. Prevention and control of tuberculosis in correctional facilities: recommendations of the Advisory Council for the Elimination of Tuberculosis. *MMWR* 1996;45(No. RR-8).

CDC. The role of BCG vaccine in the prevention and control of tuberculosis in the United States: a joint statement by the Advisory Council for the Elimination of Tuberculosis and the Advisory Committee on Immunization Practices. *MMWR* 1996;45(No. RR-4).

CDC. Surveillance of tuberculosis and AIDS co-morbidity--Florida, 1981-1993. *MMWR* 1996;45(2):38-41.

CDC. Tuberculosis morbidity--United States, 1995. *MMWR* 1996;45(18):365-70.

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in New York City. *N Engl J Med* 1996;334:828-33.

Kenyon TA, Valway SE, Ihle WW, Onorato IM, Castro KG. Transmission of multidrug-resistant *Mycobacterium tuberculosis* during a long airplane flight. *N Engl J Med* 1996;334:933-38.

Pilote L, Tulskey JP, Zolopa AR, Hahn JA, Schechter GF, Moss AR. Tuberculosis prophylaxis in the homeless. A trial to improve adherence to referral. *Arch Intern Med* 1996;156(2):161-65.

Sassan-Morokro M, Greenberg AE, Coulibaly IM, et al. High rates of sexual contact with female sex workers, sexually transmitted diseases, and condom neglect among HIV-infected and uninfected men with tuberculosis in Abidjan, Côte d'Ivoire. *J Acquir Immune Defic Syndr Hum Retrovirol* 1996;11(2):183-87.

Sbarbaro JA. Commentary on tuberculosis surveillance. *Public Health Rep* 1996;111:32-33.

Shafer RW, Bloch AB, Larkin C, et al. Predictors of survival in HIV-infected tuberculosis patients. *AIDS* 1996;10:269-272.

Smith KC, Starke JR, Eisenach K, Ong LT, Denby M. Detection of *Mycobacterium tuberculosis* in clinical specimens from children using a polymerase chain reaction. *Pediatrics* 1996;97(2):155-160.

## TRAINING AND EDUCATIONAL MATERIALS

Videotapes of the course *A Satellite Primer on Tuberculosis* have been edited and are available for purchase. The videotapes

should be used as a supplement to the *Self-Study Modules on Tuberculosis*.

Session I: "Transmission and Pathogenesis of Tuberculosis"

Presenter: Paula Fujiwara, MD, MPH

Session 2: "Epidemiology of Tuberculosis"

Presenter: Eugene McCray, MD

Session 3: "Diagnosis of Tuberculosis Infection and Disease"

Presenter: William Bailey, MD

Session 4: "Treatment of Tuberculosis Infection and Disease"

Presenter: Nancy Dunlap, MD, PhD

Session 5: "Infectiousness and Infection Control"

Presenter: Patricia Simone, MD

Videotapes are available for purchase through the Alabama Department of Public Health (ADPH). The price is \$25 per videotape or \$125 for the complete set of five. All orders should be addressed to:  
Video Communications Division  
Bureau of Health Promotion & Information  
Alabama Department of Public Health  
434 Monroe Street  
Montgomery, AL 36130-3017  
Tel: (334)613-5300  
Fax: (334)240-3045

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For readers who have access to WONDER, back issues of the MMWR can be viewed by using the "Request and Response" menu item to search the MMWR database for specific words or phrases. Once the desired article has been found, it can be downloaded via WONDER for printing or viewing.

Alternatively, WONDER users can use the "Browse" and "Info Exchange" options to download a "PDF" file of a current (this year's) MMWR article. PDF files can only be viewed using Acrobat Reader software, which can also be used to print selected articles, or search an issue for key words and phrases. This software is available for free distribution from the Adobe company's World Wide Web site at <http://www.adobe.com/>.

For readers who have access to the Internet or the World Wide Web communication and information networks, the Internet sites at the following addresses contain a variety of health-related information and provide lists of pertinent resources.

#### CDC

<http://www.cdc.gov>

Many health-related pages, including current information for travelers. For information on tuberculosis or on DTBE, start here at CDC's home page, then click on "Health Information," which will connect you with information about specific diseases, or on "Other Sites," which will lead you to the pages for NCHSTP and other sites. Also, click on "MMWR" to view back issues of that publication.

#### COMMUNICABLE DISEASE SURVEILLANCE CENTRE

<http://www.open.gov.uk/cdsc/cdschome.htm>

The Public Health Laboratory Service (PHLS) of England and Wales is a national network comprising public health laboratories, reference laboratories, and the Communicable Disease Surveillance Centre.

#### MED HELP INTERNATIONAL

<http://telemedical.com/~drcarr/>

Med Help International Inc. (MHLI), a non-profit organization, is a premier provider to patients and their families of qualified medical information, encompassing most illnesses and diseases. All medical information is offered to the patient in lay (non-technical) terminology, so that informed treatment decisions can be made within the short time lines dictated by their medical condition.

#### MEDICAL EDUCATION INFORMATION CENTER

Department of Pathology and Laboratory Medicine, U. of Texas (Houston) Medical School

<http://medic.med.uth.tmc.edu/>

#### MEDICAL MATRIX-GUIDE TO INTERNET CLINICAL MEDICINE RESOURCES

<http://www.kumc.edu:80/mmatrix/>

#### MEDICINE (BIOSCIENCES)

<http://golgi.harvard.edu/biopages/medicine.html>

#### MED NEXUS

<http://www.mednexus.com/>

Med Nexus is a new and exciting Internet-based on-line service for physicians and other medical care providers that combines comprehensive support services with a resource-rich World Wide Web site. Med Nexus is a free service to registered users

#### MEDSCAPE

<http://www.medscape.com/>

Medscape, for health professionals and interested consumers, features peer-reviewed articles, color graphics, stored literature searches, and annotated links to Internet resources. Access is free, but you must first register as a user.

#### MULTIMEDIA MEDICAL REFERENCE LIBRARY

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<http://www.tiac.net/users/jtward/>

This page was designed to facilitate access to medical information resources for medical professionals, students, and patients.

#### THE NATIONAL HEALTH INFORMATION CENTER

<http://nhic-nt.health.org/>

For toll-free information numbers, federal clearinghouses, and other resources on hundreds of topics ranging from "accidents" and "AIDS" to "x-rays."

#### NATIONAL INSTITUTES OF HEALTH (US) LIBRARY-ADDITIONAL SITES

<http://libwww.ncrr.nih.gov/addsite.htm>

An excellent starting point to on-line health information, scientific journals, and books.

#### TB TEACHING MODULE

There is a TB teaching module published by William Detmer and Eliseo Perez-Stable who are at UCSF and Stanford. It is available on the World Wide Web at

<http://www-med.stanford.edu/MedSchool/DGIM/Teaching/Modules/TBcases.html/>

#### THE ULTIMATE BIOMEDICAL INTERNET DIRECTORY

<http://www.yahoo.com/health/tree.html>

To get the most comprehensive listing of health related sources available on-line. The URL "<http://www.yahoo.com/>" leads to an index of sources of information other than biomedicine.

#### THE WORLD HEALTH ORGANIZATION WORLD WIDE WEB SERVER

<http://www.who.ch/>

### PERSONNEL NOTES

Regina Bess was selected for a graphics position in the Agency for Toxic Substances and Disease Registry. Regina, a Visual Information Specialist, has produced high-quality graphics for DTBE for the past 3½ years. Her last day with the division was March 15.

Lorna Bozeman joined DTBE on April 1 as an Epidemiologist with the Research and Evaluation Branch. From December 1990 through March 1996 she worked for the Agency for Toxic Substances and Disease Registry, and before that she was a microbiologist with the Clinical Immunology Branch of NCID.

Ed Bruner has left DTBE to begin a full-time detail that is expected to last at least 6 months with the Program Evaluation Branch, Division of HIV/AIDS Prevention (DHAP). Ed will help initiate and implement strategies for evaluating HIV/AIDS prevention activities. His work will include helping senior staff of the branch plan and convene meetings, review and award cooperative agreements and contracts, and develop mechanisms to monitor these processes. Ed reported to DHAP on May 13.

Dale Burwen, a medical epidemiologist with the Surveillance and Epidemiology Branch, resigned from DTBE on May 3 to pursue a Preventive Medicine Residency at Johns Hopkins University in Baltimore. Dale came to work for the division in July 1992; prior to that, she worked as an Epidemic Intelligence Service (EIS) officer in the Hospital Infections Program of NCID.

Dennis Christianson, the division's newest program consultant, has accepted a position as one of three Program Coordination Officers in the new Program Coordination Unit of NCHSTP. Dennis

began his career with CDC as a Public Health Advisor in September, 1983, with the VD (STD) Division as a Disease Intervention Specialist (DIS) assigned to Indianapolis, IN. His subsequent assignments with the STD program were in Alameda County (Oakland), CA, and San Francisco. In June 1989 he transferred to DTBE, assigned to New Orleans. From July 1991 through June 1992, he attended Syracuse University on long-term training, earning a master's degree in Public Administration. Upon completion of his graduate studies, DTBE assigned him to Albany, NY, as the senior Public Health Advisor. In March 1996 Dennis transferred to headquarters as a Program Consultant with DTBE. Dennis will be working with Los Angeles, Rhode Island, and Vermont. He began in his new position on April 29.

Brenda Dunagan has been selected for a Budget Analyst position with NIOSH. Brenda came to DTBE in 1986 as a Staff Assistant in the Office of the Director, and was promoted to the position of DTBE Administrative Officer in 1988. She played a key role in the growth of the division from a staff of 40 or 50 to our current staff level of about 100, with concomitant significant increases in DTBE's operating budget. Brenda's last day with DTBE was March 29.

Juanita Elder has been selected for the Program Analyst position formerly held in DTBE by Lynn Mercer. Juanita has been a federal employee since 1980 and joined CDC in December 1987. She has extensive experience as a contract specialist in CDC's Procurement and Grants Office. Juanita earned her undergraduate degree in education from Georgia Southern and her masters in education was earned from the University of Georgia. Juanita has developed an interest and superb skills in

computer-aided design and drafting and knows some American Sign language. Juanita reported on June 24.

Nick Farrell, formerly with our center's STD prevention division, has accepted a position as one of three Program Coordination Officers in the new Program Coordination Unit of NCHSTP. Nick has a degree in Public Health - Health Policy Administration from the University of North Carolina at Chapel Hill. He started with CDC's Division of STD/HIVP in September 1986 as a Public Health Advisor assigned to Detroit, Michigan. In February 1989, he reported to DSTD/HIVP headquarters on a 2-year detail to work on special projects (program assessments, research projects, development of the Infertility Prevention Project, development of STDMIS). Shortly thereafter, he began to work with project areas. Since 1989, Nick has worked with prevention programs in STD, HIV, and directly funded community-based organizations. In September 1995, he was assigned to the Division of STD/HIVP as a Program Consultant. He will be responsible for Florida, South Carolina, and the City of San Francisco. He began in his new position on April 29.

Susan Graham will be resigning from CDC to go to medical school. Susan officially joined DTBE in May 1995, although she had worked in the division in 1990 as an intern with the Association of Schools of Public Health and from March 1994 through April 1995 as a Visiting Fellow. She has been involved in developing and revising training and educational materials for the division; most recently she was responsible for organizing the TB Program Managers Course held June 17-21 in Atlanta.

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Laurie Gulaid is resigning from her position as deputy director of the Clinical Services Unit, Bureau of TB Control, of the New York City Department of Health. Laurie has been assigned to the New York City TB control program for the past 3½ years. She is relocating to Accra, Ghana, where her husband has been assigned by UNICEF.

Kate Hedstrom has been appointed project manager of the Tuberculosis Information Management System (TIMS) effective April 28, 1996. As the TIMS Project Manager, Kate will coordinate tasks related to TIMS development, testing, implementation, operation, and maintenance, including training and support. She will work closely with the TB Program Consultants to convey all necessary information regarding TIMS to field staff.

Jeannette Houston has accepted a position as a Budget Assistant with CDC's Financial Management Office. Jeannette started with the Communication and Education Branch of DTBE as an Office Automation Assistant in August 1995, and in November 1995 she was promoted to secretary. Her last day with DTBE was June 14.

Robin Huebner has resigned from CDC effective May 31 to pursue other career opportunities in South Africa. In 1995, Robin established DTBE's first international research site in Botswana, the BOTUSA project. Robin was responsible for seeing that staff were hired and trained, facilities and supplies were acquired, studies were started, and the laboratory was upgraded. The initial studies included surveillance of drug resistance, tuberculin skin testing evaluation of BCG-vaccinated children, and a physician survey about TB

knowledge, attitudes, and practices. Her last day with DTBE is July 26.

Sherry Hussain will be returning to DTBE on July 8 to serve as the secretary for the Communication and Education Branch. Sherry was the branch secretary in the DTBE Research and Evaluation Branch before transferring in September 1995 to the NCHSTP Travel Office.

Scott Jones has been selected for the public health advisor position in the City of New Orleans TB control program. Scott has been on assignment to the Kentucky TB control program since August 1993. He transferred from Frankfort to New Orleans on May 26.

Shelia Jones has been selected as a Staff Specialist in the Office of the Director, DTBE. Shelia comes to the division from the Epidemiology Program Office of CDC. She joined DTBE on March 18.

Tom Kenyon has transferred to Botswana to continue oversight of the BOTUSA project that was established by Robin Huebner. In the next phase of the project, new studies regarding clinical diagnosis and treatment are being started. Tom will be responsible for overseeing these new medical epidemiologic studies. We would also like to share the good news that Tom has been selected as the co-recipient of CDC's 1996 Alexander D. Langmuir Award. This is a highly regarded award among CDC epidemiologists.

Victoria Lee has accepted the position of Visual Information Specialist in the Computer and Statistics Branch, where she will be responsible for the production of graphics. Formerly a Visual Information Specialist with IHPO, Victoria comes with outstanding recommendations from others

in the graphics field. Victoria joined the division on May 28.

Cynthia Marshall, formerly with our center's STD prevention division, has accepted a position as one of three Program Coordination Officers in the new Program Coordination Unit of NCHSTP. A graduate of Spelman College, she has been with CDC since September 1983, beginning her career as a Disease Intervention Specialist (DIS) with the Baltimore City Health Department. She has had field assignments with the STD Program in West Palm Beach, Dade County (Miami), Florida and Raleigh, North Carolina. In August 1994 she was transferred to headquarters with the Program Operations Branch of the Division of HIV/AIDS Prevention where she served as a Project Officer with the National and Regional Minority Organizations (NRMOS) Initiative and for a number of state health departments and community-based organizations. Cynthia will be responsible for Washington, D.C., Texas, and the City of Houston. She began in her new position on April 29.

Dennis Minnice is resigning from his position in the Michigan TB program on July 6, 1996. He has accepted a position with the TB program in the City of Chicago Department of Health. Dennis came to work for DTBE and was assigned to the Chicago TB program in October 1988. He was assigned to the Wisconsin TB program in July 1990 and then to the Michigan TB program in November 1992. We look forward to an ongoing working relationship with him in his new position with the City of Chicago.

Fay C. Neal has joined the division as the new Administrative Officer, replacing Brenda Dunagan. Fay, who comes to

DTBE from CDC's Division of Oral Health, started on April 15.

Katrina Pollard has accepted a Health Communications Specialist position in the Communication and Education Branch of DTBE. Katrina will have lead responsibility for developing and implementing health communication and technical information activities in the division. Katrina was most recently a Public Health Affairs Specialist with the Agency for Toxic Substances and Disease Registry. Previously, from 1989 to 1991, she served as a Technical Information Specialist with NCCDPHP, and from 1979 to 1989 she was the Advertising Manager and Assistant Editor for the weekly newspaper the *Atlanta Voice*. Her experience in publications, technical information systems, and media relations will be a great asset to the division. Katrina started with DTBE on May 28.

Edwin Rodriguez has been selected for the vacant public advisor position in the New York State TB program. Since April 1992 Edwin has been assigned to the Puerto Rico TB control program. He transferred from San Juan to Albany on May 26.

Dan Ruggiero has been selected for the vacant Program Consultant position in the Field Services Branch of DTBE. Since June 1993, Dan has been assigned to the Missouri Department of Health, where he has been the state's designated TB program manager. Prior to joining CDC in 1993, he worked for the New York City Department of Health for 20 years in the Bureau of TB Control. From 1980 through 1993, he was the city's TB program management officer. Dan will transfer from Jefferson City to Atlanta on July 21.

Louis Salinas has accepted the position of Chief of the new Program Coordination

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Unit in the Prevention Support Office of NCHSTP. Louis has an undergraduate degree from the University of Texas (Austin) and a Masters degree in Public Policy & Administration from California State University - Long Beach. He began his CDC career in 1974 with the STD Program in San Antonio, followed by an assignment to Miami. He joined DTBE in 1976 and has had field assignments in Los Angeles, California and San Juan, Puerto Rico. He came to headquarters in January 1986, and except for a brief stint with CDC's International Health Program in 1991, he served as a Program Consultant for DTBE during this 10-year period. He has had several TDYs to New York and special assignments to Angola, Brazil, and Mexico. For the past several years he has served as the Program Consultant for the New York City TB control program as it successfully faced significant outbreaks of multidrug-resistant TB. Louis began his new assignment on March 18.

Joanne Stone has been selected for the position of branch secretary in the Research and Evaluation Branch of DTBE. Joanne held a secretarial position with the Division of Birth Defects and Development Disabilities of CDC's National Center for Environmental Health prior to coming to DTBE. She began working for REB on March 4.

Mano Timajchy has left DTBE to pursue a degree in electrical engineering at the Georgia Institute of Technology. Mano has been a Network Administrator with the division since May 1991, providing invaluable computer and network support to division staff. He played a key role in designing and installing the network services that we use daily to do our work. His last day with CDC was June 21.

Vic Tomlinson has accepted an assignment to the Missouri TB control program. Vic has been the senior Public Health Advisor assigned to the Louisiana TB control program since May 15, 1994. He will transfer from New Orleans to Jefferson City on July 7.

Wanda Walton has been selected to participate in a graduate program at the University of Alabama at Birmingham (UAB). In September, she will enter the doctoral program in health education/health promotion at the UAB School of Public Health. This training will enable her to develop more effective educational interventions for health care workers and more effective interventions for TB patients. We would also like to congratulate Wanda for receiving the prestigious Award of Excellence in the Instructional Product Category from the International Society for Performance Improvement (ISPI). The competition for awards is quite fierce. Wanda received this award in Dallas on April 18 in recognition of her leadership in planning and implementing the "Satellite Primer on Tuberculosis with Self-Study Modules on Tuberculosis." ISPI only allowed one recipient for the award; however, others who contributed significantly to both the Satellite Primer and the Self-Study Modules included Patricia Simone, MD, and Michelle McMacken from DTBE and Cheryl Tryon from the Division of Media and Training Services in PHPPO.

## CALENDAR OF EVENTS

July 7-12, 1996  
XI International Conference on AIDS  
Vancouver, Canada  
Registration Bureau  
Tel:(604) 280-1996  
Fax: (604) 682-6430

July 17, 1996  
Preventing Occupational Transmission  
of TB  
San Francisco, California  
Training Coordinator  
Francis J. Curry National TB Center  
(415) 502-4600

July 19-21, 1996  
46th Annual Tuberculosis/Respiratory  
Disease Institute  
“Learning from the Past...for our Future  
Health”  
Black Mountain, North Carolina  
American Lung Association of NC  
(800) 892-5650 or  
(919) 832-8326  
Fax (919) 856-8530

September 5-7, 1996  
National TB Controllers Meeting  
Atlanta, Georgia  
Bill Good  
CDC  
(404) 639-8116

September 9, 1996  
TB 101  
Newark, New Jersey  
Debra Bottinick  
NJ Medical School National TB Center  
(201) 982-3270

September 18, 1996  
TB Overview  
San Francisco, California  
For nonclinical health workers and social  
service staff, covering the basics of TB.  
Training Coordinator  
Francis J. Curry National TB Center  
(415) 502-4600

October 2-5, 1996  
1996 IUATLD Conf. on Global Lung Hlth  
Paris, FRANCE  
Intnatl Union against TB & Lung Disease  
Tel. (33-1) 44-88-25-25

Fax (33-1) 40-26-04-44

October 3-4, 1996  
TB Intensive  
Newark, New Jersey  
Debra Bottinick  
NJ Medical School National TB Center  
(201) 982-3270

October 18, 1996  
Mantoux Tuberculin Skin Test Course  
Newark, New Jersey  
Debra Bottinick  
NJ Medical School National TB Center  
(201) 982-3270

November 6-8, 1996  
TB Program Manager's Course  
Newark, New Jersey  
Debra Bottinick  
NJ Medical School National TB Center  
(201) 982-3270

November 12-14, 1996  
TB Intensive  
San Francisco, California  
Training Coordinator  
Francis J. Curry National TB Center  
(415) 502-4600

December 2, 1996  
TB and the Law  
Newark, New Jersey  
Debra Bottinick  
NJ Medical School National TB Center  
(201) 982-3270

December 9, 1996  
TB Update II--Directly Observed Therapy:  
An Overview  
Newark, New Jersey  
Debra Bottinick  
NJ Medical School National TB Center  
(201) 982-3270

December 11, 1996  
TB Update

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San Francisco, California  
Training Coordinator  
Francis J. Curry National TB Center  
(415) 502-4600

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